

**San Bernardino County**  
**Department of Behavioral Health (DBH)**  
**Funding Request for the Mental Health Services Act (MHSA)**  
**COMMUNITY PROGRAM PLANNING**

**Introduction**

The County of San Bernardino, located in Southern California and bordering the metropolitan areas of Los Angeles and Orange Counties, is the largest land area in the continental United States, containing more than 20,000 square miles. The County consists of three unique geographic areas: the Inland Valley, the San Gabriel and San Bernardino Mountains, and the Mojave Desert. With 1,709,434 residents (Census 2000), the County population has grown 20.5% since 1990, much of this influx from neighboring counties.

The County's population reflects a variety of unique characteristics, including a higher proportion of children and youth than most California counties. While the proportion of children under age 18 in California in 2000 was 27.3%, it was 32.3% in San Bernardino County. Notably, San Bernardino County's population is increasingly culturally, racially and linguistically diverse. Some 39.2% of the population is of Hispanic/Latino origin. African-Americans comprise 8.8% of the population and Asians/Pacific Islanders, a broad racial and cultural category, comprise 4.9% of the population in our County. Native Americans comprise 0.6% of the County's population. County residents over the age of 65 are 8.6% of the population, which is lower than California's 10.6% proportion of older adults. However, our Desert and Mountain areas are home to larger proportions of retirees and older adults than is the Inland Valley. Among County residents over the age of 5, some 34% report a language other than English spoken in the home. The County's homeless population is estimated at 8,351 people at any given time, many of which are mentally ill.

The County's growth in the past two decades can be partially attributed to the lower cost of housing, compared to adjacent counties. Thus, it's lower than average per capita income level and relatively lower median income could be viewed within that context. However, the County's "below poverty" statistics have remained higher than the average poverty statistics for California for some time.

San Bernardino County's sheer size and its distinct geographical regions complicate any effort to provide a simple "snapshot" of its residents and their resiliencies, strengths, stressors, community issues, mental health consumer experiences, perceptions of the mental health system, or highest priorities. The urban/suburban Inland Valley region contains a variety of socioeconomic, racial, cultural and ethnic groups and presents several access dilemmas. The Mountains are comprised of several defined communities with unique and even differing indigenous resource networks, service needs and concerns. The Desert area includes cities and small towns, far and wide, throughout the upper and lower Desert region. This obviously presents the local mental health system

with a myriad of informal collaboratives, unique access issues, differing expectations of the mental health system and significant levels of resiliency among stakeholders.

Recent migration into all three County regions has taxed public resources, increased vehicle traffic, prolonged commutes, and increased stressors on families and communities in unexpected ways. The recent 2003 Wildfire disaster, along with the budget crisis, placed extra demands and burdens on public agencies and a number of communities. Geographical access to services is a continual challenge recently made worse by the 2003/2004 budget crisis.

Attachment A-2 is a map of the County with markers indicating the locations of DBH and contract mental health and alcohol/drug clinics throughout the County. Obviously, services have historically been provided primarily in the population centers within the Inland Valley region. Although we have seen swift population growth in the upper Desert region, resources have grown modestly there. However, the long distance between population centers and the need for access to service for those living in isolated or smaller towns continue to present the local system with service delivery challenges. This promises to be an item of keen interest as we self-assess the issue of accessibility of resources.

In 2002/2003, the DBH developed a formal Strategic Plan designed to initiate a transformation of the local mental health system toward a consumer-involved, Recovery oriented model. A comprehensive stakeholder-driven Strategic Plan for Children & Families was developed in early 2003. This Plan was integrated into the DBH's general Strategic Plan, intended to move toward a family-focused, outcome-oriented "Discovery" model for children and families. The budget crisis during this period pre-empted full implementation of the plans made toward system transformation. The Mental Health Services Act offers San Bernardino County the opportunity to renew its focus on reaching out to the stakeholder network and building capacity for comprehensive and ongoing system planning, implementation and evaluation. The DBH has established a committee structure and membership that includes stakeholder and consumer groups to assist with the community planning process. Attachment A-3 depicts a committee and staffing structure that includes strong stakeholder participation in policy and planning of the system transformation. The organizational structure also reflects proposed staffing plans to support the Program Planning process.

We are submitting the following Community Program Planning Funding Request for your review/approval. We look forward to working together toward a dynamic mental health system transformation.

## **1. Community Program Planning must include consumers and families**

The MHSA planning process will initiate a major shift in the local mental health system that impacts not only service delivery but the way in which stakeholders interact, identify problems, set priorities, make decisions, create and allocate resources, determine effectiveness and achieve objectives. For our DBH, this initiative represents more than

an opportunity to perform a routine needs assessment with minimal information or to fill the “highest profile” gaps in service. Instead, this MHSA Program Planning effort represents an opportunity to open the doors of our system, to meaningfully include consumers and their families, to find underserved consumers, to reach out to potential consumers and to interact within their communities. While it is the DBH’s responsibility to initiate a dialog and to articulate the Vision and the Mission of a transformed mental health system, it is also our hope that an expanded stakeholder network will immeasurably enrich the dialog.

The enriched dialog promoted by consumer/family involvement will facilitate access to stakeholder perceptions of the mental health system, mental illness, community challenges and strengths, family resiliencies, non-traditional solutions and strategies, desired individual and system outcomes, and opportunities for productive system transformation. Attachment A-3 outlines the proposed committee structures that will include consumers and stakeholders at all levels of the planning process. The proposed planning process will entail a proactive outreach effort designed to meet consumers and potential consumers in their own communities, using strategies suggested by stakeholders and consumers/family employees and adjusting feedback forums to the regional/cultural characteristics found in each community. The ongoing feedback process will endeavor to communicate findings, joint decisions, new questions, and upcoming projects through an interactive relationship among stakeholders and the local mental health system. The following describes the proposed plan for initiating the dialog.

#### **A. Description of Outreach and Other Activities to Insure Comprehensive Participation from Diverse Consumers and Families**

Given the County’s size, its diverse population, and the variety of socioeconomic issues and stressors, our effort to include consumers and their families must be varied and flexible. To ensure that our County’s planning process is inclusive of consumers and families, the County will implement MHSA outreach services in settings that are familiar and comfortable to consumers and their families. Existing consumers will be reached through community clinics consumer-driven group meetings which consumers find comfortable and productive because the peer support aspect is already established within that setting. For those consumers not inclined to participate in these groups, the County will pursue alternative community settings and venues for gatherings in which consumers/families can participate in activities such as focus groups, educational forums, community meetings, and peer brainstorming groups. Linguistic needs will be assessed and addressed as events are planned, publicized and facilitated. Further, the proposed consumer/family outreach worker (see section 3, page 9, Consumer, Family & Indigenous Worker description) will identify obstacles and solutions to ensure broad participation. Resources and supports, discussed below, will be utilized in order to facilitate and sustain engagement with consumers and families.

Collaboration with Partner Agencies and Advocate Groups: The staff of the local mental health system maintains working linkages with public agencies in the coordination of services to community members. In addition, a variety of self-help, consumer advocacy

groups are present among the DBH's network. These partners will be crucial resources for reaching consumers in a variety of venues. The County will then deploy outreach and facilitator staff suited to the regional, cultural, linguistic and other unique issues to ensure maximum participation is achieved.

Feedback Loop: Information will flow freely from one group to another; from planners to stakeholders and back. This will be accomplished through an efficient communication system. A publicly accessible website will host all MHSA planning activities, meeting schedules, plans, and upcoming events. To close the feedback loop, the site will also provide instant messaging to accept responses that will be posted directly back to the primary planning groups. A single-access-point "group e-mail" box will be established to insure all stakeholders can view and respond to real-time information about the planning process. Newsletters will broadcast up-to-the-minute MHSA activities and will be distributed by stakeholders, and at locations throughout the service system.

## **B. Consumers not Belonging to Organized Advocacy Groups**

Linkage and Outreach with Indigenous Community-Based Resources: For those consumers and families not likely to be identified through public agencies or consumer/advocacy groups, creative and non-traditional methods of outreach will be employed. For example, local radio stations have previously welcomed public service announcements (PSA's) and community residents have responded. A culturally competent, stigma-sensitive vernacular will be used to ensure that these efforts resonate with highly diverse, multi-lingual, underserved, and economically depressed sections of the County. In addition, local churches, often serving as surrogate mental health providers, will serve as full partners, assisting us to determine how consumers can be reached and to understand the needs of the faith-based community in its role as MHSA stakeholder and partner.

School-linked Collaboration/Outreach: The varied geographic communities of the County, the linguistic diversity among residents, the high proportion of youth among our residents and the long distances between communities suggests that a school-based outreach is also warranted. In some communities, the school is the neighborhood center for families with school-age children. Collaboration with school personnel and access to school space after school hours will result in parent attendance at informational meetings regarding opportunities to participate in planning or in "parent partner"/advocacy groups. Teachers will be able to identify for us the mental health issues that would resonate with parent groups for discussion. In addition, contact with school children will offer access to parents whose mental health needs may not emerge until they gain access to an inclusive consumer-driven "parent partner" group.

## **C. Outreach to Underserved/Unserved**

For those who are underserved, there may be several issues affecting the “underserved” status. Consumers who have been underserved may have received insufficient amounts of service due to the lack of geographical access, the possible lack of certain types of service offered in their community clinic, the lack of linguistic capability to provide certain service or the consumer’s avoidance of the appropriate service due to stigma or other broad cultural reasons. The “unserved” consumer presents an altogether different challenge in that the local mental health system can only make assumptions regarding who should and should not be a consumer unless we venture into the community and join with local stakeholders to find unserved potential consumers.

Thus, for both groups, we will employ deliberate and focused outreach efforts, using indigenous facilitators and publicity to identify and attract and bring to the table underserved and unserved/potential consumers within the diverse communities of the County. Because communities often know who is troubled, the County will seek input from neighborhoods and initiate a dialog regarding a community’s “mental health status”, perceptions of the mentally ill, and expectations of the mental health system. The County’s partner agencies, health care providers and the faith-based community will be crucial resources as we initiate a comprehensive outreach effort to identify underserved and unserved consumers and their families.

The homeless mentally ill are an example of a difficult to reach and underserved consumer population. The homeless typically have limited access to media or other forms of information, thus more creative methods will be needed to connect and encourage involvement with the planning process. These methods can include distributing information where the homeless frequent, for example, grocery stores, downtown areas, malls, bridges, and parks. Additionally networking and establishing alliances with community support systems already used by the homeless, like the Salvation Army and Social Security offices, will be helpful in connecting with the underserved and unserved sectors of this population. Critical to this process will be to offer and provide easily available incentives such as meals, transportation, housing, to assure initial and ongoing consumer involvement.

#### **D. Methods to Obtain Consumer and Family Involvement**

Methods: It is expected that an expanded staff base which includes indigenous consumer and family workers will add methods to the “arsenal” to be used to obtain consumer and family involvement. However, based upon a current understanding of the County’s geography, diversity and collaborative resources, we expect to utilize the following methods to connect with consumers and families:

- Focus Groups
- Client Advisory Groups
- Consumer and Family Group Meetings
- Media Announcements (PSA’s)
- Newsletters
- Neighborhood Canvassing

- Informational Booths (Market Nights, Community Events, Health Fairs)
- Presentations to Community Groups, School Personnel, Faith-Based, PTA's
- Self-help, Clubhouse & Consumer-based Group Meetings
- Internet Communications
- Community Meetings with Partner Stakeholders (DCS, ADS, consumer groups)

### **E. Consumer and Family Groups Participating in Mental Health Policy Development & Program Planning**

The planning process will also result in formalizing the role of the consumer and family group in mental health policy and planning. The DBH currently has participation by the Parent Partner program in children's system of care policy/planning and consumer representation on the Mental Health Commission, which has a role in the review of policy and resource issues. However, the MHSA planning effort is intended to develop and implement a formal structure for substantive involvement of consumers/families in policy development, implementation, evaluation and planning. The overall goal is to have consumers and family groups represented on all MHSA workgroups and to have them participate as full partners in the implementation of the local mental health system transformation.

A network of on-going consumer and advocacy groups serve as a strong support net for those consumers already participating in the service system. These consumer-driven programs include clubhouses in the High Desert and East Valley communities of Victorville, Morongo Valley, Lucerne Valley, San Bernardino and Rialto. Recovery Centers in the Western region provide a safe place for consumers to gather and acquire/reinforce everyday living skills. Pathways to Recovery, a popular, supportive link helps ease seniors through life changes and provides caregivers with support and consultation for the many challenges of caring for an aging parent, preventing premature institutionalization. These consumer groups will serve as a foundation for seeding the focus group process and for establishing consumer and family groups participation in program policy and planning.

### **F. Resources and Supports**

The proposed staffing expansion will include outreach and training coordination, consumer/family and indigenous staff in order to facilitate and support an inclusive and effective planning process throughout the mental health system. It is anticipated that the following resources will be provided to assure optimum family and consumer involvement. Refer to budget and budget narrative for detailed discussion of anticipated costs in these areas.

- Transportation funding support (e.g., mileage reimbursement, bus passes)
- Child care
- Food (meals, refreshments and snacks for meetings, focus groups)
- Training Resources (discussed in Section 4)

- Lodging

## **2. Community Program Planning must be comprehensive and representative.**

### **a. Provide a Description of Ways Stakeholders Will Be Involved In Planning**

The DBH has a variety of formal linkages with education, special education, schools, law enforcement agencies, health and social services agencies, developmental disabilities agencies, acute care hospitals, the full array of child serving agencies, senior services providers, homeless service providers and other community-based organizations. Current DBH contract relationships, including managed care FFS providers, alcohol/drug and community mental health services represent a “hub” of providers that are linked to each other, to consumers and to related advocacy and community resources in their service areas. This provides an effective channel for reaching out to local stakeholders, asking for active participation and involvement as we embark on intense planning and system development.

In addition to this DBH-centered network system, we have in our County the benefit of many interagency networks. One example is the Children’s Network, a formal array of County child-serving agencies joined in collaborative efforts since 1988. Supported by the Network’s Policy Council with membership by the Directors of each agency, policy development, training, resource planning and problem resolution takes place within this Network. The County’s tradition of this type of interagency collaboration has resulted in immediate positive participation by partner agencies in the local MHSA workgroups recently initiated and convened.

The County has established MHSA planning workgroups with partners from County Schools, Public Health, law enforcement, the Department of Children’s Services (Child Welfare), community-based mental health providers, consumer advocates, parent partners, senior services providers, the Mental Health Commission, Probation, Children’s Fund, specialty Courts, the Mental Health and Justice Consensus Committee, the Children’s Network and the Homeless Coalition. Work groups are currently expanding the stakeholder list for their focus area in order to expand input to each group and to explore methods for reaching out to stakeholder groups in the future.

### **b. Ways of Insuring Stakeholder Diversity**

As indicated in the discussion above, a culturally competent, linguistically capable, and non-traditional strategy must be employed throughout the County to ensure that consumers, community partners and other stakeholders are identified, feel welcome and can participate as equal partners in the local system transformation. Work groups and leadership staff are particularly interested in injecting our planning discussions with the consideration of the County’s cultural diversity. Each workgroup will continually review available information regarding (1) the County’s expansive geography, (2) varying “cultures” that develop around geographical identities, (3) the racial, ethnic/cultural

characteristics of consumers and potential consumers, (4) the age groups found in the different regions of the County, (5) gender issues and impacts on mental health needs, and (6) agency and service provider self-assessment in relation to cultural diversity.

### **3. Clear designation of responsibility for Community Program Planning**

- a. San Bernardino County plans on utilizing the services of two consultants, who will have the responsibility of coordinating the planning process for the Community Program Planning portion of the MHSA. This work will equal 1.0 position (see below)
- b. The organizational work of the planning process will be supported by an Administrative Coordinator, who will organize, coordinate, and maintain meeting schedules and trainings; disseminate information to DBH staff, stakeholders, focus groups, communities. This position also participates on MHSA Planning Committee. This work will equal .5 position.
- c. Outreach and Training Coordinator(s): Responsible for coordinating the development of outreach strategies for reaching unserved, underserved consumers, culturally diverse populations. Provides substantial support to and works with consumer employees, parent partners, stakeholders on facilitation input/involvement in on going planning process. Assists in preparation of “feedback loop” materials such as newsletters. Eventually responsible for developing self-help, client-driven peer support network and collaboration with staff on development of mental health awareness, and stigma reduction strategies. Participates in analyses of stakeholder input. Development of and assistance with presentations, videos, displays for presentations such as focus groups, “classes”, market nights, public meetings, community forums, and media announcements, consumer group and advocacy group meetings. Responsible for developing self-help, client-driven peer support networks and collaborating with staff on development of mental health awareness, stigma reduction strategies. Participates in analysis of stakeholder input. Responsible for conducting and coordinating training and orientation of staff, stakeholders, and consumers on MHSA, development of recruitment strategies for consumer/indigenous workers, liaison with education institutions, linkage with stakeholder groups and coordination of training, liaison with cultural competence/minority services coordinator on training and recruitment. This work will equal 2.0 positions
- d. Two consultants, as Coordinators, will be utilized, as described above. The two consultants that will be utilized are both retirees and formerly Program Manager II level positions within the San Bernardino County DBH. They have worked consistently since retirement within the DBH management infrastructure, organizing and participating in special projects, retaining and enhancing collaborative relationships within the DBH and other agencies, and have strong ties to partner agencies and



consumer/advocacy groups. Their most recent work was in the FEMA-funded Wildfire Recovery Project, which ended on December 22, 2004. They bring vast experience in managing numerous County programs, children's interagency collaboration, community based organization, networking, program development, and a breadth and depth of experience in the implementation of projects to the DBH and the County. This work will equal 1.0 position.

- e. Other positions proposed, which may be DBH , contracted, or consultant staff includes the following:

Staff Analyst II: Provides support to the Fiscal Unit, fiscal expertise to planning process; consultation to fiscal interagency stakeholders group on braided/blended funding issues. Performs maintenance of effort and MHSA compliance. Provides support to management/administrative staff in development, implementation of MHSA effort, with the focus on needs assessment, interagency collaboration, development of MOU's, linkages with fiscal staff, involvement with intra- and interagency protocols. Provides technical support to enable non-traditional program activities such as stipends for consumer employees, travel reimbursement for stakeholders, childcare support for MHSA community group parent attendees. Assists in preparing, analyzing, reporting of stakeholder input. This work will equal 2.0 positions.

Statistical Methods Analyst: Provide technical support to program staff and community/agency stakeholders in performing ongoing data evaluation, needs assessment, goal-setting, and data analysis. Assists in gathering and interpreting data for review by workgroups. Collaborates with workgroups on setting outcome oriented objectives and measurement strategies. This work will equal 1.0 position.

Clerk III: Provide clerical support to MHSA management/administrative and Coordinator staff. Arranges and takes minutes at multiple MHSA stakeholder involvement groups and work group meetings. Types complex needs assessments, data analyses, proposals, and other documents. This work will equal 2.0 positions.

Consumer, Family & Indigenous Outreach Workers: Serves as liaison to unserved, underserved communities. Defines nontraditional strategies for reaching and involving potential stakeholders. Conducts focus groups. Develops strategies for supporting participation of consumers in MHSA strategic planning. Assists in development of community-based stakeholder networks. Many of these multiple positions, equaling 6,435 work hours over a period of 6 months, will be part time.

#### **4. Full Participation in Community Program Planning requires training of stakeholders and staff in advance**

**a. Description of Types and Amounts of Training Provided by County**

The County will identify staff who are familiar with target communities, gathering places, acceptable strategies for addressing mental health issues within families and skills for assisting families with troubled children. For areas known to have populations with high concentrations of mono-lingual (non-English) speakers, linguistically capable outreach staff will need to be recruited. The diverse issues to be addressed and the flexibility required warrant a coordinated training component within the planning effort. As consumers, families, staff and other stakeholders are folded into the broadened network, training for all participants will be essential so that involvement and progress toward a shared vision are always evident.

**b. Training Topics**

Below is a Training Plan outlining the array of topics, which have been prioritized for the initial phases of the planning process. Stakeholder groups (audience) are listed along with training topics. Some topics will be designed and offered to specific audiences; however, all stakeholders are welcome to attend. The Outreach and Training Coordinators will be responsible for providing and/or arranging for ongoing orientation to the local system Mission/Vision, the background of the public mental health system, system of care/community services and support, the MHSA and the concepts of resilience and recovery. However, in order to ensure expert and timely training, the County will identify and utilize outside trainers for many of the topics areas listed.

Training Topics:

- Background on the public mental health system, systems of care and the MHSA
- Implementing Recovery Oriented Systems of Care
- Concepts of Resilience and Recovery (Discovery for Children/Families)
- Designing Innovation Projects with Recovery Values
- Cultural Competence
- Establishing Self Help Groups
- Working with Co-Occurring Disorders
- Identification of the County's underserved and unserved communities
- Overview of County demographic data, including provider/staff data
- Conducting successful facilitation groups and interactive public hearings
- Making effective system changes
- Background on consumer and family-operated services
- Hiring consumers as direct service providers
- Implementing consumer operated services
- Transitional age youth specific services

Stakeholders:

- Consumers and their families
- Mental health management and supervisors
- Mental health line staff
- Mental health contract providers
- Alcohol-Drug staff, including contract providers
- Partner agencies (law enforcement, health, social services, employment, education, criminal justice, acute psychiatric hospital providers, residential care providers, and other non-traditional stakeholders)
- Mental Health Commission members
- Other stakeholder groups (as they are identified)

**5. Community Program Planning Budget Worksheet w/ Narrative**

Attached.